070885 NOV -5 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 33 S 6-2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Carol — MIDDLE: LEE ~~Brasure~~ — LAST: Alexander

2a. DATE OF DEATH — MONTH: NOV — DAY: 1 — YEAR: 1987

2b. HOUR: 9:15 a M

3. SEX: FEMALE

4. RACE: WHITE

5. DATE OF BIRTH — MONTH: APR — DAY: 25 — YEAR: 1939

6. AGE (IN YEARS LAST BIRTHDAY): 48 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): DELAWARE

7b. CITIZEN OF WHAT COUNTRY?: U.S.A

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico — MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): HOUSEWIFE

12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland — 13b. COUNTY: Wicomico — 13c. CITY OR TOWN: Salisbury — 13d. INSIDE CITY LIMITS? YES [ ] NO [X] — 13e. STREET ADDRESS / ZIP CODE: 125 Jackson Dr 21804

14. FATHER'S NAME — FIRST: CALVIN — MIDDLE: — LAST: BEASURE

15. MOTHER'S MAIDEN NAME — FIRST: Blanche — MIDDLE: E. — LAST: Donaway

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO — (IF YES, GIVE WAR OR DATES):

16b. SOCIAL SECURITY NO.: 220-34-9775

17. INFORMANT — ADDRESS: Ronald J. Alexander — Same as 13e

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 1) Metastatic Lung Cancer — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF (b): 2) Pneumonitis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/26, 19 87, to 11/1, 19 87, that (I) (~~was~~ last saw the deceased alive on 11/1, 19 87, and that in (my) (~~the~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~did~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: [signature] — DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 11/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Joseph A. Grasso

22e. ADDRESS: 145 E. Carroll St Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 11-4-1987

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem Pk

23d. LOCATION — CITY OR TOWN: Salisbury — COUNTY — STATE: Md.

24. FUNERAL DIRECTOR — NAME: Baker & Bounds — ADDRESS: Salisbury Md.

25a. DATE REC'D. BY REGISTRAR: NOV 4 1987

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

071005 NOV -6 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 33563 REG. NO.

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Edward — MIDDLE: F. — LAST: Boston
2a. DATE OF DEATH — MONTH DAY YEAR: NOVEMBER 2, 1987
2b. HOUR: 1103 M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH — MONTH DAY YEAR: Oct 12, 1921
6. AGE (IN YEARS LAST BIRTHDAY): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md
7b. CITIZEN OF WHAT COUNTRY?: U.S.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico — MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Postmaster
12b. KIND OF BUSINESS OR INDUSTRY: USPS

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Md
13b. COUNTY: Somerset
13c. CITY OR TOWN: Pr Anne
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET ADDRESS / ZIP CODE: Rt 2 Box 70 21853

14. FATHER'S NAME — FIRST: Charles — MIDDLE: S. — LAST: Boston
15. MOTHER'S MAIDEN NAME — FIRST: Nellie — MIDDLE — LAST: Pryden
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes — (IF YES, GIVE WAR OR DATES): WWII
16b. SOCIAL SECURITY NO.: 218-12-1050
17. INFORMANT — ADDRESS: Mrs Thelma P. Baton — Rt 2 Box 70 Pr Anne, Md 21853

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Arrest
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Previous myocardial infarction - Diabetes Mellitus

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY — HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from 3-16- 19 85, to 11-2- 19 87, that (I) (we) last saw the deceased alive on 11-2- 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: James L. Clifford
DEGREE: MD — ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 11/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): James L. Clifford M.D.
22e. ADDRESS: Suite 12 Medical Center Salisbury Md

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: Nov 5, 1987
23c. NAME OF CEMETERY OR CREMATORY: Beechwood
23d. LOCATION — CITY OR TOWN: Pr Anne — COUNTY: Somerset — STATE: Md
24. FUNERAL DIRECTOR — NAME: James L Hinman Jr — ADDRESS: Pr Anne, Md
25a. DATE REC'D. BY REGISTRAR: NOV 5 1987
25b. REGISTRAR'S SIGNATURE: [illegible]

071537 NOV 12 87

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 87 33564

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: Harold	MIDDLE: Jefferson	LAST: COATES	2a. DATE OF DEATH MONTH DAY YEAR: NOVEMBER 8 1987	2b. HOUR: 0330 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 11 21 1926	6. AGE (IN YEARS LAST BIRTHDAY): 60 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Branch Manager	12b. KIND OF BUSINESS OR INDUSTRY: Lance Products		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Salisbury	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET ADDRESS / ZIP CODE: 303 Glendale DR. 21801	
14. FATHER'S NAME FIRST: Thomas	MIDDLE: Leith	LAST: Coates	15. MOTHER'S MAIDEN NAME FIRST: Gladys	MIDDLE	LAST: Fishel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): Yes	(IF YES, GIVE WAR OR DATES): Airforce	16b. SOCIAL SECURITY NO.: 230-24-0745	17. INFORMANT: Fay T. Coates	ADDRESS: Same as 13e	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PULMONARY EMBOLUS
DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY BYPASS SURGERY
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION: 10/28/87	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: CORONARY ARTERY DISEASE	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from OCT. 19 19 87, to NOV. 8 19 87 that (I) (we) last saw the deceased alive on NOV. 8 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Nicholas L. Ogburn	DEGREE: MD	ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X]	22c. DATE SIGNED: 0335 11/8/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): NICHOLAS L. OGBURN MD.	22e. ADDRESS: SUITE 25 MEDICAL CENTER W. SALISBURY MARYLAND		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11-11-1987	23c. NAME OF CEMETERY OR CREMATORY: Dry Run Christian Church	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Fort Valley Shenandoah VA.	
24. FUNERAL DIRECTOR (NAME): BAKER AND BOUNDS	ADDRESS: SALISBURY, MARYLAND	25a. DATE REC'D BY REGISTRAR: NOV 10 1987	25b. REGISTRAR'S SIGNATURE: [illegible]	

Item 16b, FIlmG633 11/20/87jab

071394 NOV 10 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

87 035565 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Ruth	MIDDLE: Amelia	LAST: Cordrey	2a. DATE OF DEATH MONTH DAY YEAR: November 2, 1987	2b. HOUR: 0203 M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: June 28, 1906	6. AGE (IN YEARS LAST BIRTHDAY): 81 YRS	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: ----		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Delaware	13b. COUNTY: Sussex	13c. CITY OR TOWN: Delmar	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET ADDRESS / ZIP CODE: R.F.D. #1 19940

14. FATHER'S NAME FIRST MIDDLE LAST: George M. Perdue	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Millie Parker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES): ----	16b. SOCIAL SECURITY NO.: 221-50-7129 ~~222-24-0543~~	17. INFORMANT ADDRESS: Jean Banks Delmar, DE. 19940

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Severe congestive Heart-Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CHF. COPD.

DUE TO, OR AS A CONSEQUENCE OF (c): arteriosclerosis. Atherosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: Old Stroke.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. **I certify** that (I) (this hospital) attended the deceased from 11/1/87, 19____, to 11/2/87, 19____, that (I) (we) last saw the deceased alive on 11/1/87, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: M.D.	DEGREE: M.D.	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11/2/87.
22d. PHYSICIAN'S NAME (TYPE OR PRINT): H. R. Hedg.	22e. ADDRESS: 614 E Eastern Shore Drive. SALISBURY. MD 21801.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11-5-1987	23c. NAME OF CEMETERY OR CREMATORY: Jerusalem Cemetery	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Parsonsburg Wicomico MD	
24. FUNERAL DIRECTOR NAME / ADDRESS: Short Funeral Home, Inc. Delmar, DE 19940	25a. DATE REC'D. BY REGISTRAR: NOV 09 1987	25b. REGISTRAR'S SIGNATURE:		

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 87 033566

07141 NOV 10 87

1. DECEASED NAME (TYPE OR PRINT) FIRST Lelia MIDDLE Smith LAST Hatzel
2a. DATE OF DEATH MONTH DAY YEAR November 3, 1987
2b. HOUR 0554 M
3. SEX Female
4. RACE Caucasian
5. DATE OF BIRTH MONTH DAY YEAR 12-19-1905
6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD.
10. CITY OR TOWN OF DEATH Salisbury
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Charge Attendant
12b. KIND OF BUSINESS OR INDUSTRY M211

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Delaware
13b. COUNTY Sussex
13c. CITY OR TOWN Millsboro
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS / ZIP CODE Rt #2 Box 244 99999

14. FATHER'S NAME FIRST Harvey MIDDLE D. LAST Smith
15. MOTHER'S MAIDEN NAME FIRST Elizabeth MIDDLE A. LAST Truitt
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO. 229-03-4941
17. INFORMANT Anna E. Bailey ADDRESS P.O. Box 66 Sanford, Va. 23426

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiopulmonary Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINS
DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction — HRS
DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD — YRS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/29, 19 87, to 11/3, 19 87, that (I) (we) last saw the deceased alive on 11/3, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒
22c. DATE SIGNED 11/4/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. M. Wood MD
22e. ADDRESS PHHMC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
23b. DATE 11-6-87
23c. NAME OF CEMETERY OR CREMATORY Belle Haven
23d. LOCATION CITY OR TOWN Belle Haven COUNTY Accomack STATE Va.
24. FUNERAL DIRECTOR NAME R.C. Doughty Jr. ADDRESS P.O. Box 633 Exmore Va.
25a. DATE REC'D. BY REGISTRAR NOV 09 1987
25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be examined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

071395 NOV 10 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

FOR 1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

57 33567
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Milton; MIDDLE: Norman; LAST: Hudson (Hudson)		2a. DATE OF DEATH MONTH DAY YEAR: November 2, 1987	2b. HOUR: 2020 M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 09 11 1900	6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS: HOURS, MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Camden, New Jersey U.S.A.	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired Owner	12b. KIND OF BUSINESS OR INDUSTRY: Gift Shop

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Florida	Indian River	Vera Beach	YES ☐ NO ☐	745 Royal PalmBlock 7749

14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME
FIRST: Robert; MIDDLE; LAST: Hudson	FIRST: Annie; MIDDLE; LAST: Kershaw

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
Yes	WWII	151-01-5242	Mrs. Helen M. Blore (Niece) 815 S. College Place, Princess Anne, Md. 21853

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	RUPTURED ANEURYSM - ABDOMINAL	12 hr
DUE TO, OR AS A CONSEQUENCE OF (b)	CHRONIC OBSTRUCTIVE LUNG DISEASE	15 yr
DUE TO, OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: RUPTURED ABDOMINAL AORTIC ANEURYSM

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
9-19-87	RUPTURED ABD AORTIC AN.	YES ☐ NO ☐	YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
☐		

21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE
WHILE AT WORK ☐ NOT WHILE AT WORK ☐		

22a. I certify that (I) (this hospital) attended the deceased from 9-19, 1987 to 11-2, 1987, that (I) (last) saw the deceased alive on 11-2, 1987, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. ☐

22b. SIGNATURE, DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Dennis W. Todd Jr. M.D.	☐ ☒ ☐	11-2-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
DENNIS W. TODD JR.	SUITE #25 MED. CTR. WEST SALISBURY

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	11/5/1987	Salisbury Crematory	Salisbury, Wicomico, Maryland

24. FUNERAL DIRECTOR NAME / ADDRESS	25a. DATE RECEIVED BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Holloway Funeral Home, P.A., Salisbury, Maryland	NOV 09 1987	

072207 NOV 18 87 FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 3 3 5 5 8 REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 should indicate injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) FIRST: NANCY MIDDLE: JANE LAST: LEISTER - Leister		2a. DATE OF DEATH MONTH DAY YEAR: + November 13 1987	2b. HOUR: 3:15 A M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 8-6- 1929	6. AGE (IN YEARS LAST BIRTHDAY): 58 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF LIFE): House Wife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Wicomico	13c. CITY OR TOWN: Whitehaven	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET ADDRESS: Whitehaven Rd. # 100 21865			
14. FATHER'S NAME FIRST: Harry MIDDLE LAST: Simmons		15. MOTHER'S MAIDEN NAME FIRST: Sarah MIDDLE: Pippen LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES): 217-26-0544	17. INFORMANT ADDRESS: Thurlow C. Leister, Whitehaven, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Malignant Lymphoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate couse (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from 11/5 19 87 to 11/13 19 87, that (I) (we) last saw the deceased alive on 11/12 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W E. Coll	DEGREE: MD — ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 11-13-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT): David E. Coverll, MD	22e. ADDRESS: 145 E. Carroll St. Salisbury, MD 21801		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/15/87	23c. NAME OF CEMETERY OR CREMATORY: Springhill Cem.	23d. LOCATION CITY OR TOWN: Hebron COUNTY: Wic STATE: Md.
24. FUNERAL DIRECTOR NAME: W Messick	ADDRESS: Bivalve, Md 21814	25a. DATE REC'D. BY REGISTRAR: NOV 17 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrey

BP

DHMH - 1650M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - STATE REGISTRAR

87 33569 REG. NO.

073483 DEC - 1 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified before burial.

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	Mary E. LEWIS	2a. DATE OF DEATH MONTH DAY YEAR	NOVEMBER 25, 1987
		2b. HOUR	0327 AM
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH MONTH DAY YEAR	12 30 1922	6. AGE (IN YEARS LAST BIRTHDAY)	64 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	Md	7b. CITIZEN OF WHAT COUNTRY?	U.S.
8.	MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD.
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	None	12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	Md	13b. COUNTY	Somerset
13c. CITY OR TOWN	Princess Anne	13d. INSIDE CITY LIMITS?	YES ☐ NO ☒
13e. STREET ADDRESS	Route 3		21853
14. FATHER'S NAME FIRST / MIDDLE / LAST	George P. Lewis	15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	Bessie Webster
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	No	(IF YES, GIVE WAR OR DATES)	
16b. SOCIAL SECURITY NO.	212-76-4035	17. INFORMANT ADDRESS	Mrs. Irene Lewis, Delmar, Del.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory Failure.
DUE TO, OR AS A CONSEQUENCE OF (b) Complicated pneumonia.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 10/18 19 87 to 11/25 19 87 that (I) (we) last saw the deceased alive on 11/25 19 87 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Ignatius L. DiNardo M.D.	DEGREE	M.D. ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Ignatius L. DiNardo MD	22e. ADDRESS	Peninsula General Hospital

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	Burial	23b. DATE	11/27/87	23c. NAME OF CEMETERY OR CREMATORY: Monie Cemetery
23d. LOCATION CITY OR TOWN / COUNTY / STATE	Route 3 Princess Anne; Somerset; Md.			
24. FUNERAL DIRECTOR NAME	James L. Lineman	ADDRESS	Princess Anne	
25a. DATE REC'D. BY REGISTRAR	NOV 30 1987	25b. REGISTRAR'S SIGNATURE	Julia Davidson-Landeen	

071263 NOV -9 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR STATE REGISTRAR

87 033570
REG. NO.

1. DECEASED NAME (TYPE OR PRINT): FIRST FRANCIS MIDDLE J. LAST NEKARDA

2a. DATE OF DEATH: MONTH NOVEMBER DAY 4, YEAR 1987

2b. HOUR 0758 M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: MONTH FEBRUARY DAY 11, YEAR 1914

6. AGE (IN YEARS LAST BIRTHDAY): 73 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): NEW YORK

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.

10. CITY OR TOWN OF DEATH: Salisbury

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): SUPERVISOR

12b. KIND OF BUSINESS OR INDUSTRY: PETROLEUM

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: DELAWARE

13b. COUNTY: SUSSEX

13c. CITY OR TOWN: LEWES

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: ANGOLA BEACH/19958

14. FATHER'S NAME: FIRST FRANCIS MIDDLE J. LAST NEKARDA

15. MOTHER'S MAIDEN NAME: FIRST MABEL MIDDLE LAST DRAKE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): YES (IF YES, GIVE WAR OR DATES): WWII

16b. SOCIAL SECURITY NO.: 220-09-1673-A

17. INFORMANT: NORMA N. NEKARDA, ADDRESS RD 2, BOX 1481, LEWES, DE 19958

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): MULTISYSTEM ORGAN FAILURE

DUE TO, OR AS A CONSEQUENCE OF (b): RUPTURED AORTIC ANEURYSM

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c): ASVD

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): GANGRENE COLON

19a. DATE OF OPERATION: 10/20/87

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: RUPTURED ANEURYSM

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY: HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION: STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/20 19 87 to 11/4 19 87, that (I) (we) last saw the deceased alive on 11/4 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE MD

ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: 11/4/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): CRAIG J. SCHAEFER MD

22e. ADDRESS: 510 RIVERSIDE DRIVE, SALISBURY MD 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL

23b. DATE: 11-7-87

23c. NAME OF CEMETERY OR CREMATORY: EAST NEW MARKET CEM.

23d. LOCATION: CITY OR TOWN EAST NEW MARKET, COUNTY DORCHESTER, STATE MD

24. FUNERAL DIRECTOR: NAME ZELLER FUNERAL HOME, ADDRESS EAST NEW MARKET, MD 21631

25a. DATE REC'D. BY REGISTRAR: NOV 6 1987

25b. REGISTRAR'S SIGNATURE: [signature]

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, medical examiner must be notified of once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH - 16 60M 7/84
(VRA 15, 4)

items 7 ,b film G634

FOR 1 - STATE REGISTRAR 12-1-87 sb per funeral home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 0 / 3 3 5 7 1

0 7 1 9 8 4 NOV 17 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST / MIDDLE / LAST	ANGELO /		PARROCO	2a. DATE OF DEATH MONTH / DAY / YEAR	NOVEMBER 12 87
2b. HOUR	02 12 A M				
3. SEX	MALE	4. RACE	WHITE	5. DATE OF BIRTH MONTH / DAY / YEAR	11-15-05
6. AGE (IN YEARS LAST BIRTHDAY)	81 YRS.	IF UNDER 1 YEAR MONTHS / DAYS		IF UNDER 24 HRS. HOURS / MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	GERMANY Italy	7b. CITIZEN OF WHAT COUNTRY?	GERMANY Italy	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	
9. BALTIMORE CITY OR COUNTY OF DEATH	Wicomico MD.				
10. CITY OR TOWN OF DEATH	Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	RET.
12b. KIND OF BUSINESS OR INDUSTRY	RESTAURANT				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE	MD	13b. COUNTY	WOR	13c. CITY OR TOWN	BERLIN
13d. INSIDE CITY LIMITS? YES [X] NO [ ]		13e. STREET ADDRESS	15 CAY ST. 21811		
14. FATHER'S NAME FIRST / MIDDLE / LAST	UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST / MIDDLE / LAST	UNKNOWN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	NO	16b. IF YES, GIVE WAR OR DATES		16b. SOCIAL SECURITY NO.	154-34-2121
17. INFORMANT	E. G. PARROCO	ADDRESS	BERLIN MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — YRS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) (this hospital) attended the deceased from 10/23, 19 87, to 11/12, 19 87, that (I) (we) last saw the deceased alive on 11/12, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Donald M. Wood	DEGREE MD ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED 11/12/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	Donald M. Wood	22e. ADDRESS	PAMC

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	CREMATION	23b. DATE	11/12/87	23c. NAME OF CEMETERY OR CREMATORY: SALISBURY
23d. LOCATION CITY OR TOWN / COUNTY / STATE	SALISBURY WIC MD.			
24. FUNERAL DIRECTOR NAME / ADDRESS	ULRICH F.H. BERLIN MD.	25a. DATE REC'D. BY REGISTRAR	NOV 18 1987	25b. REGISTRAR'S SIGNATURE: Jessie Bolden-Lindell

075274 DEC 87

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR STATE REGISTRAR

REG. NO. 7 3 3 5 7 2

1. DECEASED NAME (TYPE OR PRINT) FIRST: JAMES	MIDDLE: SCOTT	LAST: RICHARDSON SR.	2a. DATE OF DEATH MONTH: 11 DAY: 30 YEAR: 87	2b. HOUR: 1 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: SEPTEMBER 3, 1913	6. AGE (IN YEARS LAST BIRTHDAY): 74 YRS.	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN.:
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED XX	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico				MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): CARPENTER	12b. KIND OF BUSINESS OR INDUSTRY: CABINET			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: WICOMICO	13c. CITY OR TOWN: SALISBURY	13d. INSIDE CITY LIMITS? YES XX NO ☐	13e. STREET ADDRESS / ZIP CODE: UNION AVENUE/21801			
14. FATHER'S NAME FIRST: JOHN	MIDDLE: M.	LAST: RICHARDSON	15. MOTHER'S MAIDEN NAME FIRST: EDITH	MIDDLE:	LAST: ELLIOTT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 214-10-7186	17. INFORMANT: JAMES S. RICHARDSON, JR.	ADDRESS: 605 OAK HILL AVE. SALISBURY, MD 21801			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) PNEUMONIA

DUE TO, OR AS A CONSEQUENCE OF

(b) INTRACEREBRAL HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PULMONARY EMBOLI

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from OCT. 27, 19 87, to NOV. 30, 19 87, that (I) (we) last saw the deceased alive on NOV. 30, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert Allen	DEGREE: M.D. ATTENDING PHYSICIAN ☑ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	22c. DATE SIGNED: 11/30/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): ROBERT ALLEN	22e. ADDRESS: 560 RIVERSIDE DR., SALISBURY, MD. 21801	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): CREMATION	23b. DATE: 12-1-87	23c. NAME OF CEMETERY OR CREMATORY: SALISBURY CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SALISBURY, WICOMICO, MARYLAND
24. FUNERAL DIRECTOR NAME / ADDRESS: ZELLER FUNERAL HOME, SALISBURY, MD 21801		25a. DATE REC'D. BY REGISTRAR: DEC 13 1987	25b. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

Item 16b, Film G534 12-15-87 dw

1 - FOR STATE REGISTRAR per funeral home

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 87 33573

173793 DEC -3 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and page 4 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the examiner must be notified before this certificate is filed.

BP_____

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: William	MIDDLE: E.	LAST: RUMBLEY Sr.	2a. DATE OF DEATH MONTH DAY YEAR: 11-13-87	2b. HOUR: 10 40 PM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH MONTH DAY YEAR: 03 - 28 - 17	6. AGE (IN YEARS LAST BIRTHDAY): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Deer's Head Center	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): REPAIRMAN	12b KIND OF BUSINESS OR INDUSTRY: VENDING CO.		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: MARYLAND	13b. COUNTY: DORCHESTER	13c. CITY OR TOWN: EAST NEW MARKET	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET ADDRESS / ZIP CODE: CEDAR GROVE ROAD/21631	
14. FATHER'S NAME FIRST: WILLIAM	MIDDLE: EVERETT	LAST: RUMBLEY	15. MOTHER'S MAIDEN NAME FIRST: MIRANDA	MIDDLE:	LAST: GILLISS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): NO	(IF YES, GIVE WAR OR DATES): -	16b. SOCIAL SECURITY NO.: 214-07-7421	17. INFORMANT: REGINA ANN J. RUMBLEY	ADDRESS: RFD 1, BOX 126, EAST NEW MARKET, MD	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pneumonia, resp. arrest. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): End stage COPD.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9-10, 19 87, to 11-13, 19 87, that (I) (we) last saw the deceased alive on 11-13, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, ~~(I) (we)~~ (did) (did not) view the body after death.

22b. SIGNATURE: Elena M. Cesin M.D. — DEGREE: ATTENDING PHYSICIAN [ ] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [X] — 22c. DATE SIGNED: 11/13/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT): ELSA M. CESIS M.D. — 22e. ADDRESS: Deer's Head Center; Salisbury, Md. 21801

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): BURIAL	23b. DATE: 11-17-87	23c. NAME OF CEMETERY OR CREMATORY: OUR LADY OF GOOD COUNSEL	23d. LOCATION CITY OR TOWN / COUNTY / STATE: SECRETARY, DORCHESTER, MD
24. FUNERAL DIRECTOR NAME / ADDRESS: ZELLER FUNERAL HOME, EAST NEW MARKET, MD	25a. DATE REC'D. BY REGISTRAR: DEC 02 1987	25b. REGISTRAR'S SIGNATURE: Linda Davidson-Lindsey	

071006 NOV -6 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 60M 7/84
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 33574
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Neal	MIDDLE: Joseph	LAST: Smith	2a. DATE OF DEATH MONTH DAY YEAR: November 1, 1987	2b. HOUR: 1645 M	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 8 24 1915	6. AGE (IN YEARS LAST BIRTHDAY): 72 YRS.	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md	7b. CITIZEN OF WHAT COUNTRY?: U.S.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.		
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Fed Govt Employee	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE
Md	Somerset	Upper Fairmount	YES ☑ NO ☐	PO Box 157 21867

14. FATHER'S NAME FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST	MIDDLE	LAST
Joseph	August	Smith	Emma	Verna	Higdon

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No		217-67-0057	Linda C. Smith	PO Box 157 Upper Fairmount, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sepsis 2° to	
DUE TO, OR AS A CONSEQUENCE OF (b)	Perforated Diverticulum 2° to	
DUE TO, OR AS A CONSEQUENCE OF (c)	Bone Marrow Failure	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. **I certify** that (I) ~~this hospital~~ attended the deceased from 10/27, 19 87, to 11/1, 19 87, that (I) (~~we~~) last saw the deceased alive on 11/1, 19 87, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN / MEDICAL DIRECTOR / STAFF PHYSICIAN	22c. DATE SIGNED
Joseph A. Grasso	MD	☐ ☒ ☐	11/1/87

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Joseph A. Grasso	145 E. Carroll St. Salisbury MD

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Cremation	Nov 4, 1987	Salisbury	Salisbury Wicomico Md

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
James L. Hinman Jr.	Pr. Anne, Md	NOV 5 1987	[illegible] Davidson-Landeros

0 7 0 7 2 3 NOV -4 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

87 33575
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH 16 60M 7/84
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST: WILLIAM	MIDDLE	LAST: STANLEY	2a. DATE OF DEATH MONTH DAY YEAR: 11 1 87
2b. HOUR: 7:15 PM			
3. SEX: M	4. RACE: NEGRO	5. DATE OF BIRTH MONTH DAY YEAR: 6 1 03	6. AGE (IN YEARS LAST BIRTHDAY): 84 YRS. IF UNDER 1 YEAR: MONTHS DAYS. IF UNDER 24 HRS: HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico MD.
10. CITY OR TOWN OF DEATH: Salisbury	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Riverwalk Manor Nursing Home	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Retired.	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md.	13b. COUNTY: Dorchester	13c. CITY OR TOWN: Cambridge	13d. INSIDE CITY LIMITS? YES ☑ NO ☐ — 13e. STREET ADDRESS / ZIP CODE: 611 Wells St / 21613
14. FATHER'S NAME FIRST: Asbury	MIDDLE	LAST: Stanley	15. MOTHER'S MAIDEN NAME FIRST: Martha	MIDDLE: X.	LAST: Clark
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) — IF YES, GIVE WAR OR DATES	16b. SOCIAL SECURITY NO.: 220-44-1817	17. INFORMANT: Annie Johnson	ADDRESS: 611 Wells St. Camb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Senile Dementia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 9-12, 19 87, to 11-1, 19 87, that (I) (we) last saw the deceased alive on 11-1, 19 87, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: MD — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☑ — 22c. DATE SIGNED: 11-2-87

22d. PHYSICIAN'S NAME (TYPE OR PRINT) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial	23b. DATE: 11/3/87	23c. NAME OF CEMETERY OR CREMATORY: Vane Cem.	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Taylors Island Dor Md.
24. FUNERAL DIRECTOR NAME / ADDRESS: Stewart Funeral Home Camb. Md.	25a. DATE REC'D. BY REGISTRAR: NOV 03 1987	25b. REGISTRAR'S SIGNATURE: Julia Davidson-Landrum	

071093 NOV -9 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 33576

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM MV-3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT): FIRST Virginia; MIDDLE Grimes; LAST Thomas
2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ MONTH 11 DAY 2 YEAR 87
2b. HOUR 2:44 P.M.
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: MONTH 08 DAY 13 YEAR 1909
6. AGE (IN YEARS LAST BIRTHDAY): 79 YRS. IF UNDER 1 YR. MONTHS / DAYS; IF UNDER 24 HRS. HOURS / MIN.
2c. DATE PRONOUNCED DEAD: MONTH 11 DAY 2 YEAR 1987
2d. HOUR
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Phildelphia,Pennsylvania
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: Wicomico County MD.
10. CITY OR TOWN OF DEATH: Salisbury
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Peninsula General Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Wicomico
13c. CITY OR TOWN: Salisbury
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET ADDRESS: 104 W. William Street 21801
14. FATHER'S NAME: FIRST Martin; MIDDLE Luther; LAST Grimes
15. MOTHER'S MAIDEN NAME: FIRST Ella; MIDDLE Marshall; LAST Burk
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN): No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 165-05-5599
17. INFORMANT ADDRESS: Mrs. Elleanor Hertel (Daughter) 267 S. Third St., Philadelphia, Pa. 19106

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple injuries — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. 8/20

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
20. AUTOPSY? YES ☒ NO ☐
21a. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH
21b. TIME OF INJURY HOUR A.M. 1:55PM MONTH 11 DAY 2 YEAR 87
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2): Driver in auto/auto collision
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.): Road
21f. LOCATION STREET Rt. 349 at Old Quantico Road CITY OR TOWN Salisbury COUNTY Wicomico Co., MD STATE

22a. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐.

ACTUAL SIGNATURE Chas R. Foke for TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 11-3-87

EXAMINER'S NAME (TYPE OR PRINT) Mario F. Golle,Jr.,M.D. ADDRESS 111 Penn Street,Baltimore,MD 21201

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 11/6/1987
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION CITY OR TOWN Salisbury COUNTY Wicomico STATE Maryland
24. FUNERAL DIRECTOR NAME AND ADDRESS: Holloway Funeral Home, P.A., Salisbury, Maryland
25a. DATE REC'D. BY REGISTRAR: NOV 06 1987
25b. REGISTRAR'S SIGNATURE

07/84 25M BP
DHMH - 17 (VR A15 ME (5))

071092 NOV -9 87

FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

57 33577
REG. NO.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be detached by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 60M 7/84 (VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: EVERETT ZABRISKIE			2a. DATE OF DEATH MONTH DAY YEAR: 11-1-87	2b. HOUR: 5:15P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH MONTH DAY YEAR: 01 02 1910	6. AGE (IN YEARS LAST BIRTHDAY): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Ridgewood, New Jersey U.S.A.	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. BALTIMORE CITY OR COUNTY OF DEATH: WICOMICO COUNTY MD.	
10. CITY OR TOWN OF DEATH: SALISBURY, MD.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SALISBURY NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE): Co owner -Woodworking & Supply Co.	12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Maryland	13b. COUNTY: Worcester	13c. CITY OR TOWN: Ocean City	13d. INSIDE CITY LIMITS? YES [ ] NO [ ]	13e. STREET ADDRESS / ZIP CODE: Route #1 Box 256A Golf Course Rd 21842
14. FATHER'S NAME FIRST MIDDLE LAST: Everett Law Zabriskie			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Marion Zabriskie	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): No	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.: 135-16-2772	17. INFORMANT: Same as #13e	ADDRESS: Mrs. Marian Wheelock Zabriskie (Wife)

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

IMMEDIATE CAUSE (a): Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days.

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Atherosclerosis — 4 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from 5/22 19 87, to 11-1 19 87, that (I) (~~we~~) last saw the deceased alive on 10-30 19 87 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Earl Beardsley	DEGREE: MD	ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]	22c. DATE SIGNED: 11/2/87
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EARL M. BEARDSLEY, M.D.		22e. ADDRESS: RT. 50 & CIVIC AVE, SALISBURY, MD. 21801	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation	23b. DATE: 11/02/1987	23c. NAME OF CEMETERY OR CREMATORY: Salisbury Crematory	23d. LOCATION CITY OR TOWN / COUNTY / STATE: Salisbury, Wicomico, Maryland
24. FUNERAL DIRECTOR NAME / ADDRESS: Holloway Funeral Home, P.A., Salisbury, Maryland		25a. DATE REC'D. BY REGISTRAR: NOV 06 1987	25b. REGISTRAR'S SIGNATURE: Linda Davidson Rendell